Zarafshon Partnerships
For Scaling-Up Innovative Approaches for Rural Tajikistan
To Building Community and Health Facility Capacity
To Sustain Key Investments in Essential Maternal and Child Health Services

Cost Extension of
Cooperative Agreement No.: FAO-A-00-98-00022-00
September 30, 2002 – September 30, 2007
Panjikent and Aini Districts of Sugdh Region

CS-18 Tajikistan
Second Year Annual Report

Prepared and Edited by:
Pervez Shaukat, Program Manager, SC, Tajikistan
Tariq Ihsan, Regional Health Advisor, Pakistan
Eric Starbuck, Child Survival Specialist, SC, Westport
Sharon Lake-Post, Information & Documentation Specialist, SC, Westport

Submitted to USAID/GH/HIDN/NUT/CSGHP
October 31, 2004

TABLE OF CONTENTS

ACRONYMS AND TERMS

ACNM	American College of Nurse-Midwives
A/N	Antenatal
ANC	Antenatal Care
APO	Assistant Project Officer
ARI	Acute Respiratory Infections
BCC	Behavior Change Communication
CDD	Control of Diarrheal Diseases
C-IMCI	Community-Integrated Management of Childhood Illness
CS	Child Survival
CS-14	"Panjikent Partners," the previous CS project in Tajikistan, which ended in September 2002, of which CS-18 is a cost extension.
CS-18	The cost extension of CS-14, funded in large part through the 18th cycle of the PVO CSH Grants Program, which began in October 2002, is referred to as "CS-18" throughout this document to distinguish it from the previous "CS-14" grant, and for the sake of brevity.
CTC	Child-to-Child (health education)
DD	Diarrheal Disease
DFOD	Deputy Field Office Director
DHO	District Health Office (of the MOH)
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization (MOH program and/or CS-14/-18 intervention supporting MOH immunization activities)
feldsher	MOH Health technicians with approximately four years of medical training
FFW	Food-for-Work
FOD	Field Office Director
GMP	Growth Monitoring Promotion
HE	Health Education
HF	Health Facility
HFF	Health Facility Farm
HIS	Health Information System

HM	Health Monitor
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge, Practices, and Coverage (survey)
LOP	Life of the Project
LSS	Life-Saving Skills (for maternal and newborn care)
MCH	Maternal and Child Health
MIL	Mothers-in-Law
MIS	Management Information System
MNC	Maternal and Newborn Care (CS-18 intervention)
MOH	Ministry of Health
NERS	Nutrition Education and Rehabilitation Sessions
NIDS	National Immunization Days
OH	Office of Health of Save the Children
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD	Positive Deviance
PD/H	Positive Deviance/Hearth
PDI	Positive Deviance Inquiry
PLG	Program Learning Group (of SC's Office of Health)
PM	Program Manager
PNC	Prenatal Care
PO	Project Officer
PVO	Private Voluntary Organization
RDF	Revolving Drug Fund
RH	Reproductive Health
RHA	Regional Health Advisor (of Save the Children)
SC	Save the Children Federation/USA
SHM	Senior Health Monitor

SMT	Senior Management Team
SUB	MOH Rural Hospital (with 40 to 80 beds, staffed with pediatricians, gynecologists, and other specialists)
TA	Technical Assistance
CAFO	Central Asian Field Office of Save the Children/US
TOT	Training-of-Trainers
TTBA	Trained Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
VDC	Village Development Committee (called Village Health Committee in CS-14)
VHF	Village Health Facility
VP	Village Pharmacy
WHO	World Health Organization
WRA	Women of Reproductive Age

A. PROGRAM ACCOMPLISHMENTS

In Year 2, a total of 65 of 128 villages were identified and selected to implement CS-18 activities. Village Development Committees (VDC) identified in Year 1, were established in 20 villages in Panjikent and in 45 villages in Aini. During Years 1 and 2, CS-18 activities were implemented in a total of 81 new villages. This represents 63% of the Target villages.

Districts	Number of Villages	CS-14 Areas	CS-18 Areas	Year 1 # of VDCs CS-18	Year 2 # of VDCs CS-18	Remaining
Panjikent	140	73	67	16	20	31
Aini	61	0	61	0	45	16
Total	201	73	128	16	65	47

Of the 16 VDCs established in Year 1, 14 received training and established village pharmacies (VPs). The VDCs in 20 new villages in Panjikent received training and helped identify VPs. These VPs will receive essential drugs when a revised revolving drug fund (RDF) system is in place. All VPs continued to supply essential drugs.

During the reporting period, education on birth planning increased at the community level through trained VDC members, and at household levels by CS-18 health monitors and Life-Saving Skills (LSS)-trained midwives. Education on birth planning remained the most important component of antenatal care and was provided at the health facility and during home visits by midwives. A significant number of husbands and mothers-in-law attended antenatal care and birth planning education sessions, which is encouraging to note. During home visits made by CS-18 health monitors, many pregnant mothers and families reported making birth plans. Also significant this year, was the increased number of pregnant women who received antenatal care, and assistance during delivery, by skilled providers. Many mothers and newborns also received postnatal care within the first eight hours after delivery. A total of 31 VDCs have a better understanding of birth planning and their role in establishing community alarm and transportation systems. The five pilot VDCs continue to make funds available for transporting women with obstetric complications.

Village-based, under-five growth monitoring and development activities were carried out in 15 villages including five identified as Positive Deviance/Hearth (PD/H) pilot areas. VDC members, Ministry of Health (MOH) staff and volunteers were trained to weigh children using Salter's Scale and to tabulate and analyze data manually. Caregivers of children with moderate to severe malnutrition were counseled and received nutrition education. Very severely malnourished children were referred to health facilities.

A great success this year was the initiation of Nutrition Education and Rehabilitation Session (NERS) in four villages which had been selected as pilot areas based on the results of nutrition surveys. Positive deviance inquiries (PDI) were conducted in these villages with positive deviant (PD) families, foods, child caregiving and health seeking behaviors identified and integrated within the NERS. In one village, a 12-day long NERS session was conducted using the PD/H approach to train volunteers, CS-18 health monitors, VDC members and MOH staff. Eleven mothers and eleven malnourished children attended the NERS regularly. Every day a new menu containing staple foods and beans or Lobia (PD food), was provided by the mothers who then prepared the meals and fed the children. By the end of September 2004, NERS/PD/H sessions were being replicated in two

villages in Panjikent. CS staff were not able to establish PD/H in two villages in Aini as planned in September, because of NIDs. Documentation of NERS activities in pilot areas will continue for another 12 months.

In this reporting period, training of MOH staff, midwives, VDC members and community members, including women of reproductive age (WRA) remained one of the most important CS-18 activities. Acute Respiratory Infection (ARI), Control of Diarrheal Diseases (CDD) and Expanded Program on Immunization (EPI)/immunization trainings were extended to new villages in Panjikent and Aini. The Life-Saving Skills (LSS) trainers conducted LSS training for 64 MOH midwives in 37 villages in Aini and 14 new villages in Panjikent. There are now 136 trained midwives in Panjikent and 50 in Aini. The CS-18 health monitors also providence MNC/birth planning trainings in 79 villages of Panjikent areas, which complements the LSS training.

EPI cards and registration in new areas-The MOH has now introduced new immunization cards and registration forms which are very similar to the ones supplied by SC. This indicates the usefulness of SC's tools introduced during CS-14, to strengthen the immunization program. The fact that the MOH, in collaboration with UNICEF, has adapted and replicated these forms is a good example of successful uptake.

SC supported the MOH in organizing national immunization days (NIDs) for measles in Aini and Panjikent. CS staff helped with community mobilization through VDCs and child-to-child (CTC) trained children. CS-18 provided logistical support to the MOH for the transportation of vaccines and health workers to remote health facilities. With the support from CS-18, the MOH was able to provide messages about the measles campaign through the local television "Simo".

CTC was conducted in 20 new schools for a total of 1,667 children trained to date (CS14 +CS-18) in Aini and Panjikent (Please see the table below). These children will in turn train other children (goal of 14,780) in CTC in a classroom setting.

Staffing In this FY, CS-18 suffered from high turnover of key technical staff. The Program Manager was shifted to another USAID-funded project (MCH/RH) in October 2003, and the health Project Officer left the project early this year (February 2004). A new Project Officer who was recruited in April, also resigned in August, and the position is still vacant. The senior health monitor is supervising the health team in Panjikent, while the assistant Project Officer is supervising the health team in Aini. A total of eight health monitors work six in Panjikent, while only two are based in Aini. The field data is entered by the senior Management Information System (MIS) officer, while a pharmacist is responsible for the RDFs.

PROGRESS TOWARDS OBJECTIVES CHART

R-1: Improved health **practices** at the household level, and increased **use** of key MCH services, in rural Panjikent and Aini districts.

Indicator 1. % of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.
Indicator 2. % of 0-23 month olds whose birth was attended by skilled health personnel.
Indicator 3. % of 0–5 month olds exclusively breastfed during the last 24 hours.
Indicator 4. % of 12-23 month olds who received a measles vaccine (by maternal history).
Indicator 5. % of 12-23 month olds with cards, fully immunized (Measles vaccine is now given from age 12 months.)
Indicator 6. % of children ill with ARI or DD in past two weeks who received increased fluids and continued feeding during the illness.
Indicator 7. % of mothers who report hand washing before food preparation and child feeding, and after defecation and child defecation.
Indicator 8. % of households with children <2 which have only iodized salt for cooking.

Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
Household			
Pregnant women make birth plans involving their husbands and other family members.	600 pregnant women will have birth plans	Yes	A total of 3,015 pregnant women attended antenatal care sessions conducted by LSS-trained staff/midwives and received birth-planning education. CS-18 staff followed 399 pregnant women at home and found that they and their family members made birth plans. Training on birth planning is continuing in Panjikent and Aini districts. (ANC+BP in both CS-14/18 areas).
Mothers have and use immunization mother-based cards for their children	8,000 mothers will have cards	Yes	CS-18 staff found that a total of 8,609 (7,689+920) mothers have child's immunization cards including 4,689 mothers receiving cards this year. MOH are issuing UNICEF cards in all the villages of Panjikent and Aini.
Postpartum mothers receive check-ups by HF staff during home visits	1,800 postpartum mothers	Yes	3,597 (2681 +916) mothers received postpartum care. This is almost twice the target. LSS training is going successfully in CS-18 areas in Panjikent and Aini. (Year 2 data)
Newborns receive care from MOH health facility staff within first 8 hours of their birth.	1,800 newborns receive care within first eight hours	Yes	2,759 newborns received care within eight hours after delivery. This is 53% above the target. BLSS started in Aini and remaining villages of Panjikent. (Year 2 data)
Home deliveries attended by LSS-trained birth attendant (MOH rural health facility staff)	1,800 home deliveries	No	A total of 1,538 (942 + 596) mothers were attended by LSS-trained birth attendants at delivery. Birth planning training is going on in Aini which will improve coverage by trained traditional birth attendants (TTBA) in Year 3.
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members	1,200 children	Yes	A total of 1,667 children have received training with 314 receiving in Year 2. A total of 14,780 children attended CTC sessions held by trained children benefited and potentially spread messages.

Mothers have and use Road to Good Health cards for their children <5	400 mothers	Yes	A total of 1,796 mothers (894 in PD/H pilot areas and 902 in 10 other villages) have GMP cards. This is 349% above the target. (Year 2 data)
Husbands and MIL of antenatal women visit HFs at least once along with the A/N woman during her pregnancy	600 Husbands and MILs	Yes	237+560= 797 is the updated figure. 797 key decision makers attended antenatal care sessions. This is 133% achievement of the target. Family focused birth planning education is gearing up in Aini.
Community			
VDCs arrange health education sessions for WRA and men	120 VDCs arrange HE sessions	Yes	MOH staffs were able to conduct HE sessions and train 134 VDCs.
MOH rural HF staff, with the assistance from VDCs, conducts BCC activities with WRA	12,000 WRA reached by BCC activities	Yes	MOH HF staffs were trained on Health Education lesson plans. MOH staff and VDCs conducted HE sessions that reached 12,069 WRA.
VDCs mobilize communities for birth planning	30 VDCs	Yes	Birth Planning training provided to 31 VDCs in Panjikent. Training in Aini is planned for October 2004.
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members	30 VDCs	Yes	31 VDCs are actively providing information to family members of pregnant women.
VDCs collect and make available emergency transport funds	5 VDC will have transportation fund	Yes	5 VDCs in Panjikent have available transport funds. The project will conduct assessment of birth planning and community transport funds in Year 3.
Iodized salt made available in the villages by mobilizing business persons through VDCs	120 villages	Yes	Awareness regarding iodized salt carried out in 154 villages. Project staff has issued Iodine testing kits to VDC/MOH staff, who regularly test kitchen salts and those in the bazaar.
VDCs facilitate immunization sessions by gathering all children <2 for vaccination	120 villages	Yes	In 154 villages, VDCs facilitate routine immunization sessions as well as in national immunization days (NIDs).
VDCs make emergency transport plans	30 VDCs	Yes	31 VDCs have a better understanding of birth planning and assist families in transportation according to the birth planning protocols.
VDCs maintain emergency transport funds	5 VDC	Yes	5 VDCs received training on how to maintain emergency transport funds.
VDCs support community-based growth monitoring sessions	15 VDCs	Yes	17 VDCs support community based growth monitoring sessions.
VDCs organize Hearths in their villages	6 VDCs	Yes	August and September 2004 PDI conducted in 4 VDCs instead of 6. PD/H sessions have started in 2/4. All four pilot areas will be covered by November 2004. Workload for CS-18 and MOH staff is high therefore PD/H target will remain 4 until mid-term evaluation.
CTC health education for children conducted at schools	100 schools	No	CTC training conducted in only 20 new schools.

Homework assignments for CTC trained students to review and report back on immunization cards of their younger siblings	1,200 students	Yes	Home assignments were provided to 1462 CTC trained students.
Health Facility			
MOH rural HF staff conduct BCC activities with WRA attending HFs.	30 HFs	Yes	Staff in 31 HFs trained who conducted health education with WRA attending health facilities.
HF staff conduct ANC and postpartum check-ups	1,800 postpartum mothers	Yes	HF staff conducted PNC check-ups for 2,808 mothers. This exceeds the target by 56%. .
HFs conduct at least one immunization session per month	120 HFs	Yes	150 HFs conduct at least one immunization session per month.
Pregnant women counseled on birth planning	600 pregnant women	Yes	3,015 pregnant mothers attended ANC sessions conducted by LSS-trained staff and midwives. Birth planning counseling is part of ANC services offered by LSS-trained staff.
MOH rural HF staff counsel mothers on nutrition	5 HFs	Yes	Staff of 17 rural health facilities counseled mothers on nutrition. This also includes 4 PD/H pilot areas.
MOH rural HF staff check immunization cards during visits of children and refer children for immunization	120 HFs	Yes	CS-18 staff visited and report 124 HFs staff checking immunization cards.
MOH rural HFs conduct planned immunization sessions	120 HFs	Yes	CS-18 staff visited and report 124 HFs conduct planned immunization sessions. However, these regular immunization sessions are now conducted by all HFs in Panjikent and Aini.
MOH rural HFs use facility-based immunization registers/log books	120 HFs	Yes	CS-18 visited 87 HFs and report that MOH staff use facility-based immunization registers and log books. However, MOH-recommended registers and cards are now in use in all HFs according to newly introduced policy of the government.
MOH rural HF staff conduct one growth monitoring session per month	15 HFs	Yes	17 HFs conduct one growth monitoring session per month.
MOH rural HFs use facility based growth monitoring registers/log books	15 HFs	Yes	17 HFs use facility based growth monitoring registers and log books.
MOH rural HF staff maintain stocks of iron supplements from VPs for distribution to the antenatal mothers	120 HFs	Yes	All HFs maintain stocks of iron supplements, including 82 which also receive from VPs.
Exit interviews with pregnant women and mothers of <5s to assess and improve quality of counseling	50 exit interview	No	HF staff not trained on counseling techniques. The first exercise of exit interviews will be carried out in April 2005.

R-2: Sustained investments in key MCH services by communities and rural health facilities in Panjikent and Aini districts.

Indicator 9. % of Health Facility Farms started before October 2004, producing crops without SC support.

Indicator 10. % of all rural health facilities, which have used health facility farm (HFF) earnings to renovate, equip, or supply the facility, or support MCH services.

Indicator 11. % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month.

Indicator 12. % of Village Pharmacies with at least 65% cost recovery.

Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
Community			
VDCs assist HF staff in the formation of FFW brigades	36 VDCs	No	34VDCs continue to assist HF staff in the formation of FFW brigades.
VDCs provide technical assistance (in agriculture) to HF staff	36 VDCs	No	34VDCs continue to provide technical assistance to HF staff.
VDCs and HF staff renovate, equip, or supply facilities, or support MCH services, using revenues collected from selling harvested crops	36 VDCs	No	Only 18 HF reported having spent some money on rehabilitation..
VDCs monitor village pharmacies.	120 VDCs monitor 120 VPs	No	Only 82 VDCs monitor 82 village pharmacies. VPs formation halted due to many operational pbs with the current VPs; an evaluation will be carried out to propose a better scheme for RDF.
VDCs ensure amount owed by patients is recovered in time by VPs	120 VDCs	No	Only 82 VDCs ensure amount owned by patients is recovered in time by VPs. This is 68% achievement of the target.
VDCs ensure seed stocks in villages for HFFs	36 VDCs	No	28 VDCs continue to ensure seed stocks in villages for HFFs. This activity was monitored by USDA food monitors, which no longer work after October 1st.
Villages establish VPs	120 Villages	No	82 villages established VPs. This is 85% of the goal. Of these, 20 new VPs will be provided with drugs by November 2004.
Health Facility			
HFs with farms make plans to utilize revenues and ensure supply of seeds for the next harvest	36 HFs	No	28 HFs continue to make plans to utilize revenues.
HF staff participate in FFW brigade selection	36 HF staff	No	16 HFs continue to participate. 16 others are out in fourth cycle and do not receive FFW support.
HF staff monitor and supervise HFF brigades	36 HFs	No	16 HF staff continue to monitor and supervise.
MOH rural HF staff monitor and supervise village pharmacies	120 VPs	No	82 villages established VPs. This is 85% of the goal. Of these 20 new VPs have been organized. Operatinalization of more VPs is deferred until sound RDF mechanism is in place.
District			
Main pharmacy updates stock records	2	No	Pharmacy in Aini not established. Aini will have a similar structure of VPs once the RDF system is revised; probably in November. New system will be operated in Aini on pilot basis and taken to scale if successful both in Panjikent and Aini.

Main pharmacy distributes medicines at least once per month	2	No	Pharmacy in Aini not established. See above comments.
Funds collected from village pharmacies once every two months	120 VPs	No	Funds continue to be collected from 82 previous VPs. See above comments
RDF committee ensures replenishment of medicines when main pharmacy stocks reach 30% balance	2	No	Pharmacy in Aini not established. See above comments.
Main pharmacy maintains all procurement records	2	No	Pharmacy in Aini not established. See above comments.
Funds recovered deposited in local bank every month	0	N/A	
Quarterly coordination meetings conducted between MOH officials and RDF committee members	4 meetings	Yes	At least four meetings a year were carried out between MOH officials and RDF committee members.

IR-1: Increased household level **knowledge** of selected MCH issues.

Indicator 13. % of mothers who know 2+ postpartum danger signs.
Indicator 14. % of mothers who know 2+ newborn danger signs.
Indicator 15. % of mothers citing both rapid breathing and chest indrawing as signs of respiratory infection that should lead them to take their child to a health provider.
Indicator 16. % of mothers citing both diarrhea with blood and diarrhea lasting more than 14 days as signs that should lead them to seek treatment or advice for their child.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Household			
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members.	1,200 children	Yes	14,780 school children attended CTC sessions which were arranged by 1,667 trained CTCs students.
Community/Health Facility			
VDCs facilitate BCC activities with WRA.	30 VDCs	Yes	31 VDCs facilitated BCC activities with WRA
VDCs assist school children trained in CTC to disseminate key messages within their communities	100 VDCs	Yes	101 VDCs assisted school children trained in CTC to disseminate key messages.
BCC activities conducted with WRA to improve knowledge, care, and care seeking for postpartum danger signs	12,000 WRA	Yes	12,856 (LSS+BP+MNC H ed)
BCC activities conducted with WRA to improve knowledge, care, and care seeking for newborns	12,000 WRA	Yes	12,856 (MNC 8027+LSS 4430+BP 399)
BCC activities conducted with WRA to improve knowledge, care, and care seeking for pneumonia	12,000 WRA	Yes	A total of 11,685 WRA attended health education sessions on ARI. These included 9,889 WRA and 1,796 mothers who participated in the nutritional survey in the PD/H pilot areas and growth monitoring sessions in 10 villages. This is 97% achievement of the target.
BCC activities conducted with WRA to improve knowledge, care, and care seeking for diarrhea	12,000 WRA	Yes	BCC activities conducted for 12,069 WRA.

Husbands and MIL of antenatal women participate in HE sessions on A/N care and birth planning	600	Yes	237+560= 798 Achievement of this target depends upon willingness of husbands and MILs to attend ANC and birth planning sessions.
VDCs and MOH have regular monthly coordination meetings	120 VDCs and MOH	Yes	154 VDCs and HFs staff have regular monthly meetings.
Schools in each community conduct CTC health education sessions	100 schools	Yes	103 schools conduct CTC health education sessions through trained children. (CS-14 + CS-18)
Active counseling of pregnant women on birth planning	600 women	Yes	3,514 LSS+BP 399 = 3,913 pregnant mothers attended ANC sessions held by LSS-trained HF staff. Birth planning is part of ANC. CS-18 staff also counseled 399 mothers.

IR-2: Improved **capacity of communities** to address priority health needs of mothers and children <5.

Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy that sold medicines in past month.

Indicator 18. % of villages with a health facility, having a Village Development Committee which organized 1+ health education session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months.

Activities	Year 1 Benchmarks	Benchmark Achieved	Comments
Community			
VDCs established in new CS-18 villages	50 VDCs	Yes	65 VDCs established.
VDCs trained in community mobilization methods	50 VDCs	Yes	65 VDCs trained in community mobilization methods
VDCs monitor village pharmacies	120 VDCs	No	82 VDCs monitor VPs.
VDCs assist VPs in cost recovery of funds owed by households	120 VDCs	No	82 VDCs assist in cost recovery. .
VDCs have regular monthly coordination meetings in villages	120 VDCs	Yes	154 VDC held regular monthly coordination meetings in villages. The target exceeds by 28%.
VDCs cross visits between old and new CS-18 sites	6 VDCs	Yes	Four VDC members and four MOH workers came from Aini to Panjikent.
VPs cross visits between old and new CS-18 sites for practical training on RDF activities	10	No	
VPs supplied with appropriate antibiotics and ORS	120 VPs	No	82 VPs monitored. This is 68% achievement of the target.
Health Facility			
MOH rural HF staff support village pharmacies	120 VPs	No	MOH staff support only 82 VPs.
MOH rural HF staff participate in VDC monthly coordination meetings	120 HFs	Yes	154 MOH rural HF staff and VDCs participate in monthly coordination meetings.
District			
Main pharmacy maintains stocks of appropriate antibiotics and ORS	2	No	Pharmacy in Aini not established Aini will have a similar structure of VPs once the RDF system is revised; probably in November!!! New system will be operated in Aini on pilot basis and taken to scale if successful both in Panjikent and Aini.

RDF committee replenishes main pharmacy when stocks reach 30%	2	No	Pharmacy in Aini not established See above.

IR-3: Improved **capacity of rural health facilities** in Panjikent and Aini districts to provide quality MCH services and support community health activities.

Indicator 19. % of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.

Indicator 20. % of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.

Indicator 21. % of children <5 who have their weight plotted on growth chart.

Indicator 22. % of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.

Indicator 23. % of ANC clinic attendees who report having received iron supplements.

Indicator 24. % of LSS-trained midwives who correctly manage normal pregnancies, deliveries, and obstetric complications.

Indicator 25. % of rural health facilities that have staff trained in LSS.

Indicator 26. % of VDC meetings that have MOH staff participating.

Indicator 27. % of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.

Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
Health Facility			
HF staff trained on WHO/ UNICEF ARI case management protocols	120 HFs	No/Yes	MOH staffs in a total of 125 HF have been trained on WHO/UNICEF ARI case management in Year 1 and 2, with 54 HFs covered in Year 2. These training received by MOH staff as their internal training during monthly conference at the main hospital and not by SC staff; which is fine, because CS-18 should have implementation from MOH staff.
HF staff trained on WHO/ UNICEF Diarrhea case management protocols	120 HFs	No / Yes	MOH staffs in a total of 125 HF have been trained on WHO/UNICEF diarrhea case management in Year 1 and 2, with 54 HFs covered in Year 2. Please see above.
MOH staff trained in counseling techniques	150 MOH staff	Yes	TOT has not been conducted but MOH staff were trained in counseling techniques as part of ARI/CDD lesson plans discussion including counseling for the care provider. 314 staffs were trained. This exceeds the target by 109%.
MOH district officials conduct bimonthly supervisory visits to rural HFs	120 rural HFs will receive supervisory visits	Yes	CS-18 and MOH staff jointly visited only 89 HFs. However other visits were carried out by MOH EPI supervisor alone.
HFs equipped with basic essential instruments	90 HFs	No	SC will facilitate use of HF farm revenue for HFs for which this is available & explore raising additional private resources for the remaining HFs. This issue will be discussed in Tajikistan in early November 2004 during the visit of HQ backstop.
MOH provides vaccines and supplies to rural health facilities at least once per month	120 HFs	Yes	MOH provides vaccines and supplies to all rural health facilities at least once a month.

VP staff bring RDF drugs to HFs	120 HFs	No	Only 82 VPs do this.
MOH rural HF staff receives regular bimonthly LSS monitoring visits	90 HF staff	Yes	222 HF staff received regular bimonthly LSS monitoring visits. Achievement of target exceeds by 146%.
MOH staff given on-the-spot LSS training during monitoring and supervision	40 midwives	Yes	272 MOH staff including midwives.
MOH rural HF staff given feedback reports on antenatal, delivery or postpartum referrals	90 HF staff	Yes	HF staffs working in 89 HF in Panjikent and 45 HFs in Aini provide feedback reports.
MOH rural HFs provided with IEC materials	120 HFs	Yes	134 HFs in Panjikent and Aini provided with IEC materials.
District			
TOTs on teaching methodologies conducted with MOH district and rural health facility staff	150 MOH staff	No	
TOTs on ARI and CDD conducted with MOH district and rural health facility staff	150 MOH staff	Yes	CDD, ARI and MNC TOTs conducted. 314 MOH staff trained. This exceeds the target by 109%.
TOTs on Nutrition/Growth monitoring and management of childhood malnutrition conducted with MOH district and rural health facility staff	150 MOH staff	Yes	CS-18 staff conducted TOTs on nutrition and GMP for 102 MOH staff. MOH has also trained at least one MOH staff in all the 134 HFs
MOH district and rural health facility staff trained in LSS	120 MOH staff	Yes	163 MOH staff trained in LSS. This exceeds target by 35%.
Monthly reports submitted by rural HFs consolidated	120 HFs	Yes	134 HFs submit regularly.
MOH Staff cross visits between old and new CS-18 sites	5 MOH staff	Yes	3 MOH staff visited Panjikent from Aini

IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, and expand TFO MCH programming in Tajik.

Indicator 28. Number of CS-18 strategies successfully scaled up in new CS-18 areas.
Indicator 29. Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site.
Indicator 30. Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum.
Indicator 31. TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.

Activities	Year 2 Benchmarks	Benchmark Achieved	Comments
District			
SC staff cross visits between Khatlon and CS-18 site	10 SC staff	No	Staff visited twice in Year 1 to Khatlon
Training courses conducted by CS-18 staff for Khatlon staff	4 trainings	No	Only in Year 1.
CS-18 pharmacist provides refresher courses for Khatlon pharmacists on RDF activities			Not in the second year
CS-18 PM participates in annual meetings of SC's OH Program Learning Group	Yes	Yes	

Provision of technical materials for baseline assessments	Yes	Yes	
Technical backstopping through e-mail correspondence	Yes	Yes	
TA in formative research to develop BCC strategies and materials for MNC and Nutrition interventions, and for development of training materials and curricula for trainers of rural HF staff.	Conducted Year 1	N/A	USAID, SC/US and HOPE/MCH materials are used for MNC. UNICEF materials are used for nutrition and hand-drawn materials for MNC and nutrition
PM participates in SC regional PD/H training, and trains TFO staff in PD/H	Conducted Year 1	Yes	The new PM decided to use RHA to repeat the PD/H training and PDI activities.
TA visit from ACNM to follow-up training of MOH midwives in LSS	Conducted Year 1	Yes	The local master trainers now conduct the training on their own

B. FACTORS THAT IMPEDED IMPLEMENTATION OF THE PLAN

1. Staff turnover: SC's (expatriate) Program Manager in Panjikent and Aini, Dr. Yousaf Hayat, was transferred in November 2003 to Dushanbe to support the MCH/RH project in southern Tajikistan on a full-time basis. The CS-18 Project Officer, Dr. Sailigul, became ill, went on vacation for two months, and then resigned in early 2004. A new Project Officer was hired in April, but resigned in August. Dr. Pervez Shaukat, the (expatriate) Program Manager in Panjikent and Aini, arrived at the end of May. The project thus suffered from a lack of senior leadership from November 2003 through May 2004, during which time the Senior Health Monitor helped the team implement activities based on the workplan.
2. The project's Aini sub-office took a long time to establish due to operational problems, including staffing, communications, and logistics.
3. Due to expanded geographic coverage, the need for transportation has increased.
4. Most of the targets identified in Year 1 were achieved in Year 2.
5. High turnover of MOH staff due to seasonal or permanent migration to Russia affects the staffing in health facilities and the achievement of targets.
6. Heavy snowfall in winters and subsequent rains in summers made communication with many villages difficult.

C. TECHNICAL ASSISTANCE

TA is required for the design and printing of health education material and for the documentation of PD/H experience in Panjikent. Plans for this TA will be made during the visit of the Westport-based Child Survival Specialist to Tajikistan in early-November 2004.

D. SUBSTANTIAL CHANCES IN THE PROGRAM DESCRIPTION

There are no substantial changes from the program description in the DIP (including goals and objectives), or in the budget, site, additions or deletions of child survival or health interventions, that will require a modification to the Cooperative Agreement.

E. PROGRAM MANAGEMENT SYSTEM

Describe the program's management system and discuss any factors that have positively or negatively impacted the overall management of the program since inception.

- **Financial Management System**

  For CS-18, all financial and administrative procedures applied are compatible with SC's standard operating procedures and comply with USAID regulations. The Panjikent-based staff, including the Finance Officer and the Impact Area Health PM, liaise with SC Field Office staff based in Dushanbe, including Finance and Operations Support staff and the Deputy FO Director (DFOD), on a regular basis to discuss current project requirements and program direction in budgeting and financing. Quarterly and annual budgets are developed in Panjikent, and submitted to the DFOD and Finance Department in Dushanbe for approval. Expenditures are recorded at the time of the expenditure and monthly finance reports prepared by Panjikent staff. These reports are submitted to SC's Dushanbe Finance Department on a monthly basis, and are incorporated into the Field Office's monthly report to SC home office in Westport.

- **Human Resources**

  SC staff based in Dushanbe:

  Field Office Director and Deputy Field Office Director for Admin. and Finance (2.5% each, plus SC match for the FOD only): Provide overall guidance and relations with MOH, USAID Mission, and other organizations.

  Finance Manager (10%): Responsible for fiscal oversight and financial reporting in compliance with grant policies and procedures.

  Admin. Manager and Admin. Assistant (10% each): Responsible for administrative oversight in compliance with grant policies and procedures.

  SC Health Program Manager (25%): Responsible for technical content of training and services, staff training.

  SC staff based in Panjikent and Aini Districts:
  SC Health Program Manager (95%): Responsible for technical content of training and services, staff training and supervision.

  CS Project Officer (100%): Responsible for overall on-sight management, assisting the PM with the overall planning and implementation of CS-18 activities, including monitoring the development of community-based providers, and ensuring productive collaboration with the DHOs and other local partners. The PO is responsible for the organization and implementation of training activities for all CS interventions, including materials development, and district health planning and management for SC and MOH staff. PO provides technical support for training organized by the DHOs and health education

sessions conducted at the community level by the rural MOH health facility staff in Panjikent and Aini districts.

Assistant Project Officer (100%): The APO is responsible for assisting the Project Officer with the overall planning and implementation of CS-18 activities, particularly in Aini District, including monitoring the development of community-based providers, and ensuring productive collaboration with the DHOs and other local partners. The APO is responsible for facilitating the design/improvement of training materials, and providing technical assistance and monitoring of training courses conducted by SC and MOH staff. The APO is responsible for the overall performance of the Health Monitors, health education sessions conducted by MOH rural health facility staff, joint supervisory visits with the rural hospitals staff to health centers and health posts, and assisting the rural health facility staff with the HIS at Aini. He will also provide technical support to MOH counterparts for establishing the mother-based immunization card system.

Senior Health Monitor (SHM) (100%): The role of the SHM is very similar to that of the APO, except that her work will continue to be focused in Panjikent District.

Pharmacist (100%): Coordinates all the activities related to revolving drug funds (RDFs). The Pharmacist assists the Project Officer and is the focal person for expanding RDF activities, including establishing a main pharmacy at Aini, establishing village pharmacies in new CS-18 areas, establishing an RDF bulk purchasing committee in Aini, inputs from the MOH, assisting the Project Officer in training village pharmacists and VDC members, and keeping RDF records in compliance with project policies. Continued funding for this position may be required until the end of project life and may possibly require the creation of a few assistant positions to support this position.

Maternal and Newborn Care Monitor (LSS trainer) (100%): The MNC Monitor assists the Project Officer with MNC activities, and is the focal person for expansion of LSS training in Panjikent and Aini, mobilizing the DHO, health facility staff, and VDCs for improved maternal and newborn care. Together with SC and MOH counterparts, the MNC Monitor's responsibilities include: (1) advocacy for maternal and child health from community to district levels; (2) mobilization of women at community level for family health, focusing on maternal and newborn care; (3) inputs for training MOH personnel, VDC members, and CS-18 partners; (4) assisting with development of messages and testing innovative delivery channels (drama, song, etc.); (5) motivating and planning with MOH counterparts, and; (6) working with Maternity Department Chief Doctors.

MIS Assistant (100%): Under the supervision of the Project Officer, the MIS Assistant is responsible for the design of health information systems, data collection forms, and computer programs; training others in computing; and collection of data from the health monitors, and from pharmacy and MOH staff. The MIS Assistant is also responsible for designing questionnaires, EPI Info programs, data entry, and analysis for surveys; performing and/or supervising accurate entry of all collected data; maintaining computers in working order; and submitting data and reports in a timely manner to the appropriate person.

Seven Health Monitors (100% each): Coordinates with MOH Master Trainers to facilitate training of rural health facility staff. They are responsible for mobilizing communities in new CS-18 villages, and establishing and training VDCs. After the VDCs are established, the HMs will coordinate the activities of VDCs and MOH rural health facilities, focusing on maternal and child health issues, including referrals, birth plans, planning for emergency obstetric transportation, setting up the child registry system, etc. The HMs monitor health education sessions conducted by rural health staff, and maintain good relations with women's groups, school children who are CTC trainers, school staff, and community members. The HMs assist with rural health facility documentation and analysis of monthly reports, including those for immunization and MNC.

Finance Officer (50%): Responsible for keeping financial records and for financial reporting.

Petty Cashier (50%): Responsible for cash, radio equipment

Admin. Officer (50%): Responsible for all administrative issues including recruitment, procurement, transportation, security and general administration of the office.

Admin. Assistant (50%): Responsible for procurement, record keeping, stores and general administration of the office.

Translator (80%): Responsible for the translation of correspondence, workplans, reports, etc., from English to Russian, and Russian and Tajik to English.

Backstopping and Technical Assistance from SC's Headquarters and Regional Health Advisor: Regular technical and administrative assistance and monitoring of CS-18 from SC's home office include: provision of technical materials for baseline assessments; joint writing, review, and revision of the Detailed Implementation Plan, annual reports, and other technical documents; participation in mid-term and final evaluations; annual program review and technical assistance visits to the site; technical backstopping through frequent e-mail correspondence encouraging the field office to seek technical materials and guidance from the home office, and prompt responses to queries from Tajikistan; and regular internal and external auditing. Key SC Home Office staff supporting CS-18 include: Dr. Eric S. Starbuck, Child Survival Specialist, responsible for technical backstopping and guidance from Westport, Connecticut; and Ms. Carmen Weder, Office of Health Manager, based in Westport. Dr. Tariq Ihsan, SC's RHA for Asia, based in Islamabad, provides technical assistance and oversight, particularly with regard to planning, baseline and other assessments.

- **Communication System and Team Development:**

CS-18 management relies on established lines of communication. The Panjikent-based team arranges monthly staff meetings when all the Panjikent staff is in the office and can participate. Weekly health staff meetings provide forums for the exchange of ideas and discussions on key program issues. There is further coordination with the Agriculture project staff on overlapping areas such as CTC, school health, CDD, ARI, hygiene, water and sanitation. The routine communication between the Panjikent and the Central Asian

Field Office (CAFO) is through monthly senior management team (SMT) meetings in which the PM participates. In SMT meetings, major policy decisions about program and overall management are made. The land telephone line and e-mail system is exceptionally bad works and frequently is not working. The use of cell phones for immediate contact with higher management has helped to address this somewhat. VHF communication and pactors (a VHF communication and mailing system) system is also not reliable and less efficient.

- **Local Partner Relationships**

  The project staff works in close collaboration with MOH staff and village communities. For example, CS staff participates in all MOH sponsored activities such as NIDs. The project was able to provide logistic support to NID for Measles held this year. Through the established channels of VDC networks and CTC, awareness activities were undertaken to assist the MOH. Transportation was provided for vaccines and staff delivery. The education department is supported by USDA grant activities, including feeding and infrastructure support. SC assistance is acknowledged both by the government and the communities in which it works.

  Local MOE staff acknowledge SC support in the school feeding program under the USDA grant. SC has initiated school health and sanitation program, which have components of health and hygiene education through CTC, latrine construction and installation of hand washing stations etc.

- PVO coordination/collaboration in country

The new PM held introductory meetings with key staff of various international agencies involved in health and agriculture sector in Tajikistan; UNICEF, WHO, Merlin, WFP, German Agro Action, Pharmaciens Sans Frontier (PSF) and Deputy Minister Health MOH. This however, is an area for further consolidation and strengthening so that SC can play a major role in advocacy on health issues especially in support of MCH/RH program.

- Organizational capacity assessment

Please see Annex 2 for the November 2003 report of the Tajikistan Field Office CS-18 Baseline Organizational Assessment.

F. WORKPLAN FOR YEAR 3

CS-18 Workplan for Year 3

R-1: Improved health **practices** at household level, and increased **use** of key MCH services, in rural Panjikent and Aini districts.														
Indicator 1. % of mothers who report having made 3+ ANC visits to a health facility while pregnant with youngest child.														KPC survey
Indicator 2. % of 0-23 month olds whose birth was attended by skilled health personnel.														KPC survey
Indicator 3. % of 0–5 month olds exclusively breastfed during the last 24 hours.														KPC survey
Indicator 4. % of 12-23 month olds who received a measles vaccine (by maternal history).														KPC survey
Indicator 5. % of 12-23 month olds with cards, fully immunized (Measles vaccine is now given from age 12 months.)														KPC survey
Indicator 6. % of children ill with ARI or DD in past 2 weeks who received increased fluids and continued feeding during the illness.														KPC survey
Indicator 7. % of mothers who report hand washing before food prep. and child feeding, and after defecation and child defecation.														KPC survey
Indicator 8. % of households with children <2 which have only iodized salt for cooking.														KPC survey
Major Activities	**2004**			**2005**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
Household														
Pregnant women make birth plans involving their husbands and other family members.	X	X	X	X	X	X	X	X	X	X	X	X	LSS trained MWs, CS-18 promoters, VDCs, MOH staff, family members, volunteers	3500 pregnant women will have birth plans Collect information from midwives 3x monthly
Mothers have and use immunization mother based cards for their children	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff will provide EPI card. CS-18 promoters in areas where MOH does not give out.	3500 in Aini 3500 in Penjikent Penjikent will cover only 0-12 months.
Postpartum mothers receive checkups by HF staff during home visits	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff report on PNC for mothers at home and facility.	3000 mothers receive PNC checkups.
Newborns receive care from MOH health facility staff within first 8 hours of their birth.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2500 newborn receive care within 1st eight hours

Home deliveries attended by LSS trained birth attendant (MOH rural health facility staff)	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	3000 home and facility deliveries
Children attending CTC sessions disseminate key health messages to their mothers, fathers and other family members.		X		X		X		X		X		X	Students who receive information from CTC trained students and SC staff, teachers.	450 students trained by 1 CS-18 CTC trainer and 5 non-CS-18 health nutrition staff. Each of the 450 MT will train 10 more children so 4,500 children will be further trained next year. Cumulative target could be then can be 4,500+14,780= 23,780 students who attend CTC sessions.
Mothers have and use Road to Good Health cards for their children <5	X	X	X	X	X	X	X	X	X	X	X	X	SC staff	1,500 mothers with children 0-23 months receive GMP cards from HFs and village GMP sessions
Husbands and MIL of antenatal women visit HFs at least once along with the A/N woman during her pregnancy	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	1,000 husbands and/or MILs
Community														
VDCs arrange health education sessions for WRA and men.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	154 VDCs arrange HE sessions
MOH rural HF staff, with the assistance from VDCs, conducts BCC activities with WRA.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	15000 WRA reached by BCC activities (15000 will be the cumulative target; only Year 3 target is 3000)
VDCs mobilize communities for birth planning		X	X	X				X	X	X			VDCs and MOH,	25 VDCs Aini 30 VDC Penjikent

													midwives, volunteers	
VDCs facilitate development of emergency transport plans by pregnant women, their husbands, and other family members.	X	X	X	X	X	X	X	X	X	X	X	X	VDCs and MOH, midwives, volunteers	25 VDCs Aini 30 VDC Penjikent
VDCs collect and make available emergency transport funds				X	X					X	X		VDCs, Midwives and MOH staff, CS-18 promoters	2 VDCs Aini 8 VDCs Penjikent
Iodized salt made available in the villages by mobilizing business persons through VDCs	X	X	X	X	X	X	X	X	X	X	X	X	VDCs, Midwives and MOH staff, CS-18 promoters, CTC, Food staff	154 villages
VDCs facilitate immunization sessions by gathering all children <2 for vaccination	X	X	X	X	X	X	X	X	X	X	X	X	VDCs and MOH staff, CS-18 promoters	154 villages
VDCs make emergency transport plans	X	X	X	X	X	X	X	X	X	X	X	X	VDCs and MOH staff, CS-18 promoters	25 VDCs in Aini 30 VDCs in Penjikent
VDCs maintain emergency transport funds				X	X					X	X		VDCs and MOH staff, CS-18 promoters	2 VDCs Aini 8 VDCs Penjikent
VDCs support community-based growth monitoring sessions				X	X	X				X	X	X	SC will facilitate	2 villages in Aini 15 villages in Penjikent
VDCs organize Hearths in their villages								X	X	X	X		SC will facilitate	4 VDCs till mid-term
CTC health education for children conducted at schools	X	X	X	X	X	X	X	X	X	X	X	X	School teachers	103 previous schools and 30 new schools (this includes 20 new schools in Aini)

Home work assignments for CTC trained students to review and report back on immunization cards of their younger siblings	X	X	X	X	X	X	X	X	X	X	X	X	SC CTC promoter, teachers	1462 previous trained and 450 new students
Health Facility														
MOH rural HF staff conduct BCC activities with WRA attending HFs.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	31 previous HFs 25 new Aini 30 new Penjikent
HF staff conduct ANC and postpartum checkups	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff at facilities and in the villages where no HFs	3000 postpartum mothers
HFs conduct at least one immunization session per month	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff at facilities and in the villages where no HFs	154 HFs
Pregnant women counseled on birth planning	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	3000 pregnant women
MOH rural HF staff counsel mothers on nutrition	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	2 villages in Aini 15 villages in Penjikent (Pervez: Does this include PD hearth villages also???)
MOH rural HF staff check immunization cards during visits of children and refer children for immunization	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	107 HFs Penjikent 50 HFs Aini
MOH rural HFs use facility-based immunization registers/log books	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	107 HFs Penjikent 50 HFs Aini
MOH rural HF staff conduct one growth monitoring session per month				X	X	X				X	X	X	SC, MOH and VDCs	5 HFs in Aini 15 in Penjikent
MOH rural HFs use facility based growth monitoring registers/log books				X	X	X				X	X	X	SC will facilitate	5 HFs in Aini 15 in Penjikent
MOH rural HF staff maintain stocks of iron supplements from VPs for distribution to the antenatal mothers	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	107 HFs Penjikent 50 HFs Aini
Exit interviews with pregnant women and mothers of <5s to assess and improve quality of counseling				X				X				X	MOH Chief Ob/Gyn, MOH LSS	5 interviews in each LSS HF (5 x 80)

													trainers and CS-18 LSS trainer	

R-2: Sustained investments in key MCH services by communities and rural health facilities in Panjikent and Aini districts.														
Indicator 9. % of Health Facility Farms started before 10/04, producing crops without SC support. **Indicator 10.** % of all rural health facilities, which have used HFF earnings to renovate, equip, or supply the facility, or support MCH services. **Indicator 11.** % of Village Pharmacies with no stock out of any antibiotic or ferrous sulfate in past month. **Indicator 12.** % of Village Pharmacies with at least 65% cost recovery.														Final Eval. Final Eval. VP records RDF Reports
Major Activities	**2004**			**2005**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
Community														
VDCs monitor village pharmacies.	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs monitor 120 VPs
VDCs ensure amount owed by patients is recovered in time by VPs	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	120 VDCs
Villages establish VPs	X	X					X	X					Pharmacist	120 Villages
Health Facility														
MOH rural HF staff monitor and supervise village pharmacies								X	X				Pharmacist	120 VPs
District														
Main pharmacy updates stock records	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	1 Penjikent and 1 in Aini (establishing Aini pharmacy will depend upon results of VPs evaluation)
Main pharmacy distributes medicines at least once per month	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	1 Penjikent and 1 in Aini (establishing Aini pharmacy will depend upon results of VPs evaluation)
Funds collected from village pharmacies	X	X	X	X	X	X	X	X	X	X	X	X	Pharma	82 VPs

once every two months													cist	(establishing more VPs will depend upon evaluation of VPs)
RDF committee ensures replenishment of medicines when main pharmacy stocks reach 30% balance							X					X	SC will facilitat e	1 Penjikent and 1 in Aini (establishing Aini pharmacy will depend upon results of VPs evaluation)
Main Pharmacy maintains all procurement records							X					X	Pharma cist	1 Penjikent and 1 in Aini (establishing Aini pharmacy will depend upon results of VPs evaluation)
Quarterly coordination meetings conducted between MOH officials and RDF committee members				X				X				X	Pharma cist	3 meetings (every four months)
Biannual coordination meetings conducted between MOH district officials and Agriculture district department officials						X						X	SC will facilitat e	2 meetings

IR-1: Increased household level **knowledge** of selected MCH issues.														
Indicator 13. % of mothers who know 2+ postpartum danger signs. **Indicator 14.** % of mothers who know 2+ newborn danger signs. **Indicator 15.** % of mothers citing both rapid breathing and chest indrawing as signs of respiratory infection which should lead them to take their child to a health provider. **Indicator 16.** % of mothers citing both diarrhea with blood and diarrhea lasting more than 14 days as signs which should lead them to seek treatment or advice for their child.														KPC survey KPC survey KPC survey KPC survey
Major Activities	**2004**			**2005**									**Person nel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
Household														
Children attending CTC sessions disseminate key health messages to their	X	X	X	X	X	X	X	X	X	X	X	X	VDCs, Teacher	# of children attending CTC

mothers, fathers and other family members.													s, CTC CS-18/FACT trainers, Trained students	sessions by 1667 previously trained children # of children attending CTC sessions by 450 new trained children
Community/Health Facility														
VDCs facilitate BCC activities with WRA.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff and VDC	30 VDCs in Penjikent 25 VDCs in Aini
VDCs assist school children trained in CTC to disseminate key messages within their communities		X		X		X		X		X		X	VDCs, CTC trained students and CS-18 CTC/FACT trainers	101 previous VDCs 10 new VDCs Penjikent 20 Aini
BCC activities conducted with WRA to improve knowledge, care, and care seeking for postpartum danger signs	X	X	X	X	X	X	X	X	X	X	X	X	MOH midwives, VDC, CS-18 promoters	15000 WRA (15000 will be the cumulative target; only Year 3 target is 3000)
BCC activities conducted with WRA to improve knowledge, care, and care seeking for newborns	X	X	X	X	X	X	X	X	X	X	X	X	MOH midwives, VDC, CS-18 promoters	15,000 WRA (15,000 will be the cumulative target; only Year 3 target is 3,000)
BCC activities conducted with WRA to improve knowledge, care, and care seeking for pneumonia	X	X	X	X	X	X	X	X	X	X	X	X	MOH midwives, VDC, CS-18 promoters	15,000 WRA (15,000 will be the cumulative target; only Year 3 target is 3,000)
BCC activities conducted with WRA to	X	X	X	X	X	X	X	X	X	X	X	X	MOH	15,000 WRA

improve knowledge, care, and care seeking for diarrhea													midwives, VDC, CS-18 promoters	(15,000 will be the cumulative target; only Year 3 target is 3,000)
Husbands and MIL of antenatal women participate in HE sessions on A/N care and birth planning	X	X	X	X	X	X	X	X	X	X	X	X	MOH midwife, CS-18 promoter, VDC and Volunteers	1,000 Husbands and/or MILs
VDCs and MOH have regular monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	154 VDCs and MOH
Schools in each community conduct CTC health education sessions	X	X	X	X	X	X	X						SC will facilitate	133 schools
Active counseling of pregnant women on birth planning	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	3000 women

IR-2: Improved **capacity of communities** to address priority health needs of mothers and children <5.														
Indicator 17. % of villages with resident rural health facility staff, having a Village Pharmacy that sold medicines in past month. CS-18 Records **Indicator 18.** % of villages with a health facility, having a Village Development Committee which organized 1+ health education Session in past month, or had a VDC meeting addressing 1+ health topic in past 2 months. CS-18 Records														
Major Activities	**2004**			**2005**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
Community														
VDCs established in <u>new</u> CS-18 villages														20 Penjikent 45 Aini (strengthen work in previous VDCs in Year 3)
VDCs trained in community mobilization methods		X		X		X		X		X			MOH and SC staff	65 VDCs to revisited for community mobilization
VDCs monitor village pharmacies	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	82 VDCs (new

														VPs will depend upon results of evaluation)
VDCs assist VPs in cost recovery of funds owed by households	X	X	X	X	X	X	X	X	X	X	X	X	VDCs	82 VDCs(new VPs will depend upon results of evaluation)
VDCs have regular coordination meetings in villages once each two months	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	154 VDCs
VDCs cross visits between old and new CS-18 sites			X			X				X				4 VDCs (VDCs supporting PD/Hearth)
VPs cross visits between old and new CS-18 sites for practical training on RDF activities														Depends upon the results of the VP Evaluation
VPs supplied with appropriate antibiotics and ORS	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	82 VPs (previous established VPs)
Health Facility														
MOH rural HF staff support village pharmacies			X			X			X			X	Pharmacist collects this information	82 VPs
MOH rural HF staff participate in VDC monthly coordination meetings	X	X	X	X	X	X	X	X	X	X	X	X	SC will facilitate	154 HFs
District														
Main pharmacy maintains stocks of appropriate antibiotics and ORS	X	X	X	X	X	X	X	X	X	X	X	X	Pharmacist	1 (Aini pharmacy will be established based on VP evaluation results)
RDF committee replenishes main pharmacy when stocks reach 30%							X					X	SC will facilitate	1 (Aini pharmacy will be established based on VP evaluation results)

IR-3: Improved **capacity of rural health facilities** in Panjikent and Aini districts to provide quality MCH services and support community health activities.

Indicator 19. % of children <5 with diarrhea for whom all six diarrhea assessment tasks are completed by the health worker.	HFA
Indicator 20. % of children <5 with ARI for whom all four ARI assessment tasks are completed by the health worker.	HFA
Indicator 21. % of children <5 who have their weight plotted on growth chart.	HFA
Indicator 22. % of children's caretakers counseled on importance of continued breastfeeding or feeding food at home.	HFA
Indicator 23. % of ANC clinic attendees who report having received iron supplements.	HFA
Indicator 24. % of LSS-trained midwives who correctly manage normal pregnancies, deliveries, and obstetric complications.	ACNM LSS forms
Indicator 25. % of rural health facilities that have staff trained in LSS.	ACNM LSS forms
Indicator 26. % of VDC meetings, which have MOH, staff participating.	VDC Records
Indicator 27. % of villages with health facilities, with 1+ group health education sessions conducted by HF staff in last 2 months.	HF Records

Major Activities	**2004**			**2005**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
Health Facility														
HF staff trained on WHO/ UNICEF ARI case management protocols					X						X		MOH master trainers	196 HF staff
HF staff trained on WHO/ UNICEF Diarrhea case management protocols								X				X	MOH master trainers	196 HF staff
MOH staff trained in counseling techniques (TOT on Basic Counseling Skills)						X TOT	X T				X R		TOT CS-18 staff, field training by MOH master trainers	20 MT Penjikent targeting 15 MT in Aini Total sessions four in Penjikent and 4 in Aini.
MOH staff trained in Rational Drug Use														This training is subsumed within ARI, CDD, IMCI
Joint MOH district EPI officer and/or pediatrician, ob/gyn conduct bimonthly supervisory visits to rural HFs		X				X				X			MOH staff, CS-18 staff	At least cover 40% of the HFs.
MOH SUB supervisor conduct bimonthly supervisory visits to rural HFs.		X		X		X		X		X		X	MOH staff, CS-18 staff	At least cover 60% of the HFs
MOH provides vaccines and supplies to rural health facilities at least once per month.	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	154 HFs

VP staff bring RDF drugs to HFs	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	82 HFs (new VPs will depend upon Evaluation report)
MOH rural HF staff receives regular three monthly LSS monitoring visits.				X				X				X	SC MNC monitor	154 LSS HF staff and midwives
MOH staff given on-the-spot LSS training during monitoring and supervision				X				X				X	SC MNC monitor	154 LSS HF staff and midwives
MOH rural HF staff given feedback reports on antenatal, delivery or postpartum referrals				X				X				X	SC MNC monitor	154 LSS HF staff and midwives
MOH rural HFs provided with IEC materials (IMCI, RH/MCH, EPI)					X	X	X						SC CS-18 promoters	58 HFs
District														
TOTs on teaching methodologies conducted with MOH district and rural health facility staff														Completed in Year 2
TOTs on ARI conducted with MOH district and rural health facility staff.			X							X			SC staff	50 MOH permanent Master Trainers
TOTs on CDD conducted with MOH district and rural health facility staff.							X				X		SC staff	50 MOH permanent Master Trainers
TOTs on Nutrition/ Growth monitoring and management of childhood malnutrition conducted with MOH district and rural health facility staff						X								15 HF staff Penjikent 5 HF staff in Aini
MOH district and rural health facility staff trained in LSS		X	X	X									SC staff	8 new villages 8 new villages
Monthly reports submitted by rural HFs consolidated	X	X	X	X	X	X	X	X	X	X	X	X	MOH staff	140 HFs

IR-4: Improved **TFO capacity** to scale up successful MCH activities, present results, and expand TFO MCH programming in Tajik.														
Indicator 28. Number of CS-18 strategies successfully scaled up in new CS-18 areas. **Indicator 29.** Number of CS-18 strategies successfully scaled up by TFO beyond the CS-18 site. **Indicator 30.** Results of 1+ innovative CS-18 strategy presented at SC OH Program Learning Group or other international forum. **Indicator 31.** TFO expands MCH program implementation in Tajikistan beyond the CS-18 site.														Final Evaluation Final Evaluation PLG Report TFO Reports
Major Activities	**2003**			**2004**									**Personnel**	**Benchmarks**
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**		**Year 3**
District														
SC staff cross visits between Khatlon and CS-18 site													PM	10 SC staff
Training courses conducted by CS-18 staff for Khatlon staff													PM and PO	4 trainings
CS-18 pharmacist provides refresher course for Khatlon pharmacists on RDF activities													Pharmacist	
CS-18 PM participates in annual meetings of SC's OH Program Learning Group								X					OH SMT	Yes
CS-18 midterm evaluation											X		CS Specialist	Done
Joint writing, review, and revision of the Detailed Implementation Plan, and annual reports												X	CS Specialist	Yes
Technical backstopping through e-mail correspondence	X	X	X	X	X	X	X	X	X	X	X	X	CS Specialist	Yes
TA in formative research to develop BCC strategies and materials for MNC and Nutrition interventions, and for development of training materials and curricula for trainers of rural HF staff.													SC RHA	Conducted
PM participates in SC regional PD/H training, and trains TFO staff in PD/H													PM	
TA visit from ACNM to follow-up training of MOH midwives in LSS										X			PM	

Annex 1

Child Survival Grants Program Project Summary
Second Annual Submission: Oct-27-2004
SC Tajikistan

Field Contact Information:

First Name: Pervez

Last Name: Shaukat

Address: Save the Children Central Asia Field Office

2 proezd, 8-10 Ackademicheskay Street

City: Dushanbe

State/Province:

Zip/Postal Code:

Country Tajikistan

Telephone: 011-992-372-21-07-71 (Dushanbe), (011-992) 3475-53301 /-54395 (Panjikent project site)

Fax: 011-992-372-51-00-79 (Dushanbe)

E-mail: pervezshaukat@hotmail.com

Project Web Site:

Project Information:

Project Description:	Project Description: SC has been implementing two complementary programs in rural Panjikent District since 1998, the CS-14, now CS-18, Child Survival project, and a US Department of Agriculture supported food commodity program. CS-14 implemented innovative approaches to substantially improve the capacity of rural health facilities in Panjikent to provide sustainable MCH services, and the district's communities to address priority MCH needs and support rural health services. The project established 75 Village Pharmacies with Revolving Drug Funds, which are making essential drugs available in a sustainable way to communities and health facilities for the first time in recent years. CS-14 also developed a potentially sustainable system for communities and health facilities to raise funds to rehabilitate, re-equip, and re-supply rural health facilities through Health Facility Farms, on which food-for-work brigades farm food crops which are then sold for profit. SC and CARE have worked with the American College of Nurse Midwives and the MOH to adapt ACNM materials on Life Saving Skills for Maternal and Newborn Care for Tajikistan, and started training MOH staff in LSS in Panjikent and several other districts in early 2002. CS-18 will scale up these successful CS-14 strategies to all 202 villages in and above the Zarafshon Valley of Panjikent and neighboring Aini District, to reach approximately 96,000 beneficiaries, including 36,000 children

	under five years of age and 60,000 women between the ages of 15 and 49. CS-18 will continue support for the four CS-14 interventions: 1. ARI (at 15% of planned intervention-specific CS-18 effort), 2. CDD (15%), 3. Immunization (15%), and 4. Maternal and Newborn Care (30%); and 5. Introduce a Nutrition and Micronutrients intervention (25%). Thus, CS-18 interventions will address all principal causes of under-five deaths in Tajikistan: pregnancy/birth-related problems, pneumonia, diarrhea, and malnutrition; as well as maternal health and immunization, priority MCH interventions introduced through CS-14. The project will implement these five interventions through SC's principal CS-14/-18 partners, the districts' rural health facilities and Village Development Committees, through the six strategies developed and refined through CS-14: 1. Revolving Drug Funds for Village Pharmacies; 2. Health Facility Farms for continuing investments in improving MCH services; 3. Joint training and supervision of rural health facility staff; 4. Community mobilization through Village Development Committees; 5. Interactive engagement of local health workers with community groups to promote improved MCH practices, and; 6. Child-to-child health education. CS-18 will also introduce the Positive Deviance approach to identify and spread existing positive local maternal and/or child health practices throughout communities, initially on a small scale, and if successful, scale-up PD approaches throughout the CS-18 site.
Partners:	The rural health facilities and Village Development Committees of the CS-18 site.
Project Location:	All 202 villages in and above the Zarafshon Valley of Panjikent District and neighboring Aini District of Sugdh (formerly Leninabad) Region in northwestern Tajikistan.

Grant Funding Information:

USAID Funding:(US $)	$1,250,000	**PVO match:(US $)**	$333,300

Target Beneficiaries:

Type	Number
infants (0-11 months):	7,500
0-59 month old children:	36,000
Women 15-49:	60,000
Estimated Number of Births:	8,300

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
(No Data)	100%

General Strategies Planned:
Strengthen Decentralized Health System
M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Participatory Rapid Appraisal
Behavior Change & Communication (BCC) Strategies:
Interpersonal Communication

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ	(None Selected)	(None Selected)	Health Facility Staff	Other CBOs

Interventions:

Immunizations 15 **%**
** HF Training
Nutrition 15 **%**
** HF Training
Vitamin A 1 **%**
Micronutrients 4 **%**
** HF Training
Acute Respiratory Infection 15 **%**
** HF Training
Control of Diarrheal Diseases 15 **%**
** HF Training
Maternal & Newborn Care 30 **%**
** HF Training
Breastfeeding 5 **%**
** HF Training

Annex 2

SAVE THE CHILDREN FEDERATION
TAJIKISTAN FIELD OFFICE

CHILD SURVIVAL 18 – BASELINE ORGANIZATIONAL ASSESSMENT

November 2003

A. Background

The Tajikistan Field Office (TFO) of Save the Children (SC) implemented its first USAID-funded Child Survival project – CS14 – in September 1998. The current CS18 project, a 5-year extension of the original project, builds on the successes of CS-14 and expanding into one further district adjacent to Panjikent. In addition to CS, the TFO has begun implementation of a RH-MCH project in the southwest of Tajikistan and has ongoing projects in the areas of education and food security in other regions as well. Programs are managed out of a central office in Dushanbe and from 4 impact area offices.

The TFO conducted a Quality Management Review (QMR) in April 2002 to pinpoint priority areas where field office management needed strengthening. The QMR provided a baseline from which capacity-building plans are regularly made and monitored. Regular annual assessments of organizational capacity are carried out as part of the TFO's 3-year strategic and annual planning process. The CS18 requirement to conduct a Baseline Organizational Assessment (BOA) dovetails with this ongoing process of management capacity-building. The annual assessment will help to ensure that management capacity keeps astride of increasing demands of the TFO's multifarious projects.

B. Quality Management Review/Baseline Organizational Assessment: Process and Objectives

Quality Management Review

The QMR was conducted through a 3-day workshop in which 13 senior and mid-level TFO managers participated, using the SC Quality Management Guide as a framework (Attachment A – Quality Management Guide). Prior to the workshop, two facilitators (one independent consultant and one SC headquarters staff) worked with the TFO Senior Management Team (SMT) to develop a workshop design that would enable them to meet the following objectives:

1. Provide an opportunity to build staff understanding of components of FO management and SC's management standards;
2. Develop staff capacity to conduct and systematically follow-up management reviews;

3. Enable staff to identify areas where FO management can be strengthened;
4. Develop a management capacity-building action plan to address priority areas for strengthening;
5. Foster staff commitment to building FO management capacity.

The workshop process enabled participants to assess TFO performance against SC's agency and general management standards. Working in small, inter-departmental teams, they reviewed field office effectiveness in the six major management areas delineated in the Quality Management Guide:

- program management and operations;
- strategic planning;
- program monitoring, evaluation, and documentation;
- human resource management and staff development;
- financial management and budget control; and,
- program development and fundraising.

Each team then identified priority areas for management strengthening and developed management capacity-building action plans. (See Attachment B – QMR Workshop Documentation.) Since completion of the QMR, TFO program managers have regularly reassessed their management capacity-building plans to monitor progress and re-plan as necessary. Most recently, this was done during the FY2004 Program Operation Plan (POP) process conducted in July 2003. The POP is the annual workplan for implementing the 3-year program strategic plan (PSP); the TFO is in the final year of its PSP 2002-2004.

Baseline Organizational Assessment

The major objective of the CS18 BOA is in sync with those of the QMR: that is, providing a framework to assess, monitor and reassess the TFO's management strengths and weaknesses and to plan and implement actions to improve management capacity. The process benefits CS-18 as well as all TFO programs and projects.

The April 2002 QMR serves as the starting point for the CS18 BOA; areas for management strengthening are outlined in the action plans in Attachment B. This BOA takes into account actions undertaken since then to improve management capacity of the TFO as well as new management issues that have arisen since then. Recommendations emanating from this exercise are in addition to those in the QMR.

The BOA was conducted by independent consultant Lisa Krift through a review of relevant documentation including:

- Child Survival 14 Final Evaluation
- FY04 Program Operation Plan
- Quality Management Review Report – April 2002
- Training Needs Assessment Report – 2003
- TFO Organizational Chart
- TFO 2003 Annual Report – Management section

Information was also obtained through interviews with the following key staff in the TFO and in SC headquarters and regional offices:

- Michael McGrath, TFO Director
- Rashid Masaud, TFO Deputy Director/Finance & Administration
- Dr. Yousaf Hayat, TFO Health Advisor
- Ms. Mamadjanova Salomat, TFO PEAKS Project Manager
- Eric Starbuck, SC Child Survival Specialist

C. Key Findings

Major Changes in the TFO

The TFO's projected annual expenditures rose during the last year from US$1.3 million to US$3 million with the addition of 3 new projects including CS-18, Maternal-Child Health – Reproductive Health (MCH-RH), and Participation Education and Knowledge Sharing (PEAKS). These projects represent the core of the health and education sectoral programs of the TFO. Food security and school feeding projects are also ongoing through early 2004.

Significant staff restructuring occurred during this period as well: a new field office director (FOD) came on board in November 2002 and key positions of Deputy FOD for Programs (DFOD/Programs), Training Coordinator (TC), and Computer Systems Officer (CSO) were created and filled to provide centralized TFO-wide support. In addition, the Health Sector Coordinator (HSC), who provides support to both the CS18 and the MCH-RH projects, was redeployed from his isolated location in Panjikent to Dushanbe where he will be more accessible to the widely-dispersed TFO health project staff.

There were some improvements in the operating environment in which the TFO operates: the appointment of a new, more receptive Minister of Health is expected to facilitate partnership with government counterparts and a generally more stable security environment should ease concerns about travel and property. However, development indicators for the country were static or showed deteriorating trends. USAID funding for Tajikistan is expected to return to prevailing levels after a very substantial one-off increase, although new donors such as SIDA are establishing a presence in 2004. In Central Asia, only Uzbekistan appears likely to receive increased USAID support in the coming years.

Management Capacity Status Report

Findings in each of the six key management areas assessed at the TFO are presented in the following tables. A detailed management assessment checklist filled out during the QMR is on file with the TFO. Generally, management assessments reveal numerous areas for improvement of an organization, where management can be "tweaked". The intent of this report, however, is to focus on significant findings and recommend actions that could have the greatest impact on strengthening TFO management and achievement of goals and objectives.

The major management issue currently facing the TFO is how to balance the ongoing technical assistance needs of the CS-18 project with those of the new MCH-RH project. The Health Sector Coordinator is currently obligated under grant requirements to provide the majority of his time to the MCH-RH project through April 2004, at which time a review will be undertaken to determine a more appropriate allocation. In the meantime, the TFO has identified specific technical assistance requirements for CS-18 and has taken steps to obtain support from SC's Asia Health Technical Officer, with backstopping from the SC headquarters health unit. The CS-18 staff, virtually all of who are continuing from the CS-14 project, are well-experienced and capable.

1. Strategic Planning

Management Area/Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
Strategic Planning: • SC Vision, Mission, Strategic Planning • TFO Strategic Vision and Focus • Strategic Management • Service Delivery • Partnerships • Organizational Learning	• Much better alignment has been achieved in the last year between TFO core sectoral programs (Health, Education, Food Security) and SC's overall vision, mission and strategies. This has been made possible through a series of planning workshops that have enabled staff to gain deeper understanding of SC's strategic priorities as an agency and their role in helping achieve agency mission. • Staff do not generally make the link between strategic plan and their day-to-day activities. This may partly be caused by the fact that senior staff do not actively refer to key planning documents with regularity. A positive trend is noted, however, among senior staff,: "In the past, 0% [made the connection], but now it's 15-20%." Another senior local staff member noted that "more time is spent [during staff meetings] on projections about the future than in the past." • Over the last year, staff have been invited for the first time to share their feedback on planning documents and proposal development rather than having senior staff hand them finished products for implementation, but they still rarely take initiative with new ideas on their own. They are, however, more readily able and willing to give feedback. • There is a low but increasing level of basic program management skills – planning, monitoring and evaluation –	• There is a large gap between the program management skills of international and local staff. The international staff will need to invest significant "mentoring" in order to bring local staff up to levels where they can take on more responsibility. Until local staff are adequately trained and able to manage autonomously, program expansion will be limited. The CS18 staff are mentoring the MCH-RH staff; this model can be replicated in other projects. • TFO has rapidly developed a complex portfolio of projects. Donor and SC headquarters expectations are high. National staff management skills are still relatively low, placing considerable pressure on international management staff. • Partnerships require a special set of skills. TFO staff have limited experience in partnering but have committed themselves to working in this mode.	• FOD and senior managers have analyzed their areas of greatest need for management support and have requested technical and/or management assistance from the SC headquarters and area offices to ensure that they meet donor expectations for the new, expanded projects. Specific priorities, agreements and timetables should be committed in writing as soon as possible. • International SMT members should take time to consider specific options for devolving responsibility to local staff with minimum risk to project success. This may include a "mentoring" program, identifying training opportunities for mid-level managers, providing targeted in-house training programs for protégés. • Add an occasional management "retreat" onto the SMT meetings that focus entirely on strategic issues and planning. • In addition to a continued focus on program management skills (planning, monitoring and evaluation,), develop and conduct partnering workshops for all staff within the next year. Begin by developing staff understanding of the partnering concept, then proceed to action-planning (i.e., specific steps toward building partnerships). Obtain partnering resources from

Management Area/Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
	among field staff. A new staff position of Training Coordinator was filled, a thorough training needs assessment carried out, and a series of program management trainings has begun, with 6 workshops carried out so far. An intensive M&E workshop is scheduled for early 2004. • The Senior Management Team meetings still largely serve as a forum for decision-making on operational rather than strategic issues. However, these team meetings have evolved to team-building and skill-building opportunities: there are more members from mid-level management, consensus-building is the mode of decision-making, and minutes are kept and widely circulated. There is broader participation in decision-making. • For the first time, annual Program Operations Planning workshops were held in each impact area to ensure broad local staff input. • Partnerships are being included as key strategy for all new projects. Child Survival projects have worked with MOH through a partnership approach while new education and food security projects are struggling to find local rather than international partners. • Exchange visits have been introduced as a way to help staff understand the benefits of partnering: sharing ideas and responsibilities. • The new PEAKS project has positioned SC and TFO to expand programs and funding base into other Central Asian countries, building on past successes.		experienced SC field offices (e.g., Philippines, Nepal). • Conduct regular (i.e., annual) training needs assessment . Staff will begin to see that their ideas are used and will be more willing to offer their ideas and suggestions for trainings they need to better perform their roles and responsibilities. • Include the Training Coordinator position in all future projects to ensure that staff development remains a regular feature of TFO rather than providing ad hoc trainings.

2. Program Development & Fundraising

Management Area/Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
Program Development & Fundraising: • Procedures and Practices • Networks, Alliances, and Strategic Partnerships • Concept Paper and Proposal Development • Public Information	• A new program unit has been established centrally in Dushanbe to provide technical and management support across all impact areas and projects consisting of a DFOD/Program, Health Sector Coordinator, Program Officer and Training Coordinator. A new Computer Systems Officer, based in the Dushanbe office but with a requirement to travel extensively to support the sub-offices, has also been appointed to the Finance and Administration Division. • Partnerships are now a stated strategy of all TFO projects and all current projects work with local and/or international partners in project implementation. The aim is to develop local partners' capacity to sustain project activities. • Within the last year, the TFO's funding has become considerably more diversified than ever before, the result of a greater focus on aligning programs with SC and donor priorities. • Staff are much more substantively involved in developing project proposals. A series of consultative workshops were conducted with	• There are several new, complex projects added to the TFO portfolio, putting considerable pressure on the new program unit members. Setting priorities will be essential because of the need to show early success. The FOD will need to ensure priorities are clear so that staff are not stretched in too many directions - to the point of ineffectiveness. • The Health Sector Coordinator is currently limited to spending 95% of his time on the new MCH-RH project. CS18 staff are very experienced, but the expansion of that project to new areas will require more than the remaining %5 of his time. Timely technical assistance is required from SC's regional Health Technical Officer and other SC health technical resources. The TFO will need to prioritize and decide the best use of technical assistance and obtain necessary commitments. • There are a limited number of Tajik NGOs with which to partner. It will be necessary for the TFO to create and/or develop partners and to build their capacity. TFO staff need to improve their own skill levels simultaneously as they mentor other organizations. In particular, they need to improve their own understanding and skills in how to partner effectively. • Staff's ability to present their projects and	• Begin developing partnering workshops, with modules intended to build TFO staff skills as well as partner capacity. A number of SC field offices are already implementing advanced partnering strategies and have workshop modules available. The TC should obtain these and use as appropriate for the TFO context. • Get the M&E system, with core indicators, up and running as soon as possible for the non-health projects (health information systems are already in place). This will be essential if the TFO is to maintain credibility for expanded programming. • Identify core indicators for all projects and track progress and achievements that can be used in program briefs and/or reports for general distribution to various stakeholders: government officials, partners, donors, etc. These reports can also be used on the SC website. Photos of project activities and beneficiaries would enhance the briefs and bring life to them.

Management Area/Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
	impact area staff in developing food security proposal – first time they had been involved at more than a passive level. • Public information about program successes is still inadequate due to lack of monitoring and evaluation systems. However, systems should be in place as outcome of series of M&E workshops/technical assistance scheduled in early 2004.	achievements effectively will be hampered until they gain adequate M&E skills and systems.	

3. Human Resource Management & Development

Management Area/ Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
• Human Resource Management & Development: • Policies & Procedures • Salary Structure/ Salary Scale • Human Resource Information • Staff Development • Teamwork • Deployment of Staff Resources	• A revised TFO P&P manual has been drafted and is 99% translated into local language to ensure all staff can understand its contents. It will be reviewed by legal counsel within 2003. • TFO conducted a salary review and found that it lags behind other international organizations in its benefits and salary package. A new scale for senior managers has been put into place that will enable TFO to get on par with other organizations. A similar review of salaries for middle-level management (Project Officer level) is planned for 2004. • In addition, a new personnel appraisal system has been devised, revamped to simplify its use as a supervisory tool. It is linked to the new salary scale to ensure that pay increases are rationalized. A training is in the planning phase to provide orientation to all staff on the new system. • Staff support and technical assistance is enhanced and integrated through the creation of a Program unit in Dushanbe; previously, each project was run separately, with no central support structure to integrate them. A Deputy Field Office Director/ Program is now in place and will provide much-needed focus on program support. • There has been a significant push this past year to strengthen in-house	• There is considerable competition between NGOs and PVOs for trained staff. TFO will need to maintain a competitive salary and benefits package in order to retain staff. • It is appropriate for the new TC to focus effort on raising skill levels of impact area staff at this time. Mid-level and senior local managers, however, may require higher levels of training. SC offers some trainings at the headquarters and area levels, like the SC orientation and sectoral or finance trainings, but participants must be able to speak English to benefit. This limits the training opportunities for an important segment of staff who eventually should take on program management responsibilities. • Health staff have the bulk of new project expansion within the TFO. They will be stretched managerially due to the disproportionate distribution of the Health Sector Coordinator's time in favor of the MCH-RH. The CS18 project will require focused technical assistance from regional and headquarters technical assistance resources.	• Conduct salary reviews regularly – perhaps every year – to ensure TFO package is competitive with other organizations. • Identify local training opportunities for mid-level managers in order to build their skills, raise their motivation as team members, and devolve program management responsibilities to them as soon as feasible. Set objectives with specific timetables for doing so. • FOD and project managers need to be fully versed in all grant requirements and avoid misapplication of grant procedures that will lead to problems with donors. • The FOD and Health Sector Coordinator must ensure that MCH-RH gets on track within the 6-month timeframe in which limits have been set on the HSC's availability to assist other projects (i.e., CS18). The HSC should mentor the MCH-RH Field Operations Coordinator during this period so that she can move into more of a leadership role for the project. • A key "lesson learned" from the CS14 project was that headquarters and regional technical assistance is most crucial during the start-up phase of a project. The TFO would

Management Area/ Sub-Areas	Management Status	Challenges/Limitations	Recommendations/Areas for Strengthening
	training capability with the addition of Training Coordinator and Computer Systems Officer. The TC will assist in developing key trainings for staff, identified through a training needs assessment; there have been 6 trainings for staff in program management so far this year. The CSO will assist in maintaining computer hardware and software as well as training staff in database management (linked to M&E skills development). • The Health Sector Coordinator will theoretically provide support to all health programs in the long-term but donors are requiring that he provide 95% of his time strictly to the MCH-RH project for at least 6 months, after which his project distribution will be reviewed. The CS18 project will require some technical as well as documentation assistance during this time. TA has been requested from the Asia Regional Health Technical Officer, but has not yet been specifically scheduled.		benefit from some concentrated technical assistance from these quarters at this time. Specific TA plans should be agreed between the TFO and the regional and headquarters technical staff.

4. Financial Management & Budget Control

Management Area/ Sub-Areas	Management Status	**Challenges/Limitations**	**Recommendations/Areas for Strengthening**
Financial Management & Budget Control: • Cash Management & Control • Procurement • Travel • Equipment & Materials • Cost Share/Match Contribution	• TFO is currently taking steps to devolve financial and budget management to local project managers at the impact area level. Impact area finance staff meet monthly with finance staff in Dushanbe to review their financial reports – part of on-the-job training strategy. There is an annual Finance/Administration conference to focus on issues of particular concern and clarify policies, procedures and systems. This strategy is in line with a CS14 "lessons learned": project managers require finance and budget training, particularly if they are working in very isolated places like Penjikent. But program managers also require such training. • A system to track community contribution to projects has been non-existent to this point, but is now being drafted.	• The Finance/Admin section of the TFO now has a reasonably full complement of staff to ensure the smooth management of the various grants. No problems noted at the time of this BOA. • There is a good deal of interaction between finance staff in the impact area and Dushanbe offices that will ensure well-managed bookkeeping and accounting, but program managers, who are responsible for project budgets and expenditures, could benefit from some finance training as well in order to ensure proper coordination between program objectives and financial planning and control. • Community contribution is a necessary step in attaining project sustainability in most cases; community contribution leads to a stronger sense of ownership on the part of project beneficiaries. There has undoubtedly been significant community contribution toward projects implemented with the TFO, but it has not been fully accounted for. As a result, communities have not been given full credit for their contributions.	• Continue to take conscious steps to devolve financial and budget management to the field level, with the Dushanbe staff playing a supportive and training role (and, needless to say, final accountability role). Provide finance/admin training to program managers as well as impact area finance staff. • Complete development of and put into place a system for tracking community contribution and using it in project planning and capacity-building of local communities toward sustainability.

5. Program Management & Operations

Management Area/ Sub-Areas	Management Status	**Challenges/Limitations**	**Recommendations/Areas for Strengthening**
Program Management & Operations: • Policies & Procedures • Vehicles/Property/ Equipment • Security & Safety • Emergency Response Preparedness	• The TFO Policies & Procedures manual has been drafted and mostly translated, though the process was much behind the original schedule due to changes in senior management that delayed final approval. • Impact area offices have been upgraded; 3 of 4 offices have moved to more appropriate compounds that allow for training facilities. They also have generators that will power necessary computers and office equipment during the frequent power outages that previously interrupted the work flow. • New vehicles have been approved and will soon be available, greatly increasing field workers' mobility to accomplish project activities. • The poor telephone/e-mail system on which the TFO is reliant has been a serious deterrent to communications between the impact areas and the rest of the world, especially in Panjikent. Recent improvements in service have meant that there is now excellent email service (ADSL line) linking the Dushanbe, Kurgan-Tube and Kulyab offices. Emails to Shartuz and Penjikent continue to have to be sent using the radio-based Pactor system, which is time-consuming. The landline-based telephone service is erratic and poor quality throughout the country. The Dushanbe, Kurgan Tube and Kulyab offices are now linked by mobile telephone service, and it is hoped to provide mobile telephone service to the	• Panjikent remains an isolated location, cut off from the rest of the country for long periods in winter, a situation that cannot be overcome with the acquisition of new project vehicles. Even the mobile phone network is yet to reach Penjikent, so staff there are still reliant on the old phone system. The situation was not as critical when the Health Sector Coordinator was based in Panjikent and was available to CS14 staff at all times, but his redeployment to Dushanbe may at times cause a slower pace as the staff await his technical input. • A larger, more complex grant portfolio will likely lead to increased donor demands for information, placing more pressure on an already obsolete phone system. • Tajikistan is in a period of relative calm and quiet, but natural disasters have happened with frequency – and unpredictability. The lack of an emergency response plan means that the TFO will be caught flat-footed if a crisis strikes.	• The Policies & Procedures manual should be completed and distributed to all staff as soon as possible. Each staff member should sign a statement that he/she has read and understood the contents. Senior staff should arrange special staff meetings to review procedures and answer questions for ensuring all staff are aware of the policies and procedures. • Given the increasing demands on SC field offices to be technologically up-to-speed and competent, the TFO should review the cost-effectiveness of a satellite phone system. If found feasible, a system should be installed as soon as possible. • TFO should obtain copies of Emergency response plans from other SC field offices and review them as a first step in drafting their own plan. The Nepal FO has drafted a plan, as has the Georgia FO, among others. This will avoid re-inventing the wheel, though other countries' plans will need to

	Penjikent office in early 2004 using linkages with the Somoncom company. • The Computer Specialist Officer position was identified as a necessity as more staff are required to be efficient in using computers. This will be especially important as M&E systems are developed and data input, storage and analysis will become routine aspects of project management. The CSO will maintain all hardware and ensure appropriate software is installed and will train staff. • The security situation in the country as a whole has improved and there has been an official lifting of restrictions on travel. This will give staff more flexibility in scheduling. Some costly security procedures that were required can now be dropped, easing the budget for use on project activities instead. • The TFO does not have an Emergency Response plan in place despite having planned such more than a year earlier. It is, however, a key stated objective in the latest Program Operational Plan (POP).		be adapted for the Tajikistan context.

6. Program Monitoring, Evaluation & Documentation

Management Area/ Sub-Areas	Management Status	**Challenges/Limitations**	**Recommendations/Areas for Strengthening**
Program M/E/Doc: Program Indicators Program Impact Technical Assistance	• CS18 staff have a much higher level of program management skills, including M&E. Developing non-health staff M&E skills is a high priority for TFO. Technical assistance has been identified to conduct a series of workshops in early 2004, one result of which will be an M&E system based on core indicators. This is a very positive step toward helping staff make a major leap in their program management skills level. • The newly-appointed Computer System Officer should, in theory, provide support for the maintenance and use of the M&E system by training staff in database management and software use. • The CS18 project in-house technical assistance has been curtailed by the redeployment of the Health Sector Coordinator to Dushanbe to manage the MCH-RH project. Availability of regional and headquarters technical support has been agreed, but is not yet scheduled. • The school feeding program that has dominated the program portfolio for almost 7 years will end in early 2004 or shortly thereafter. The lack of adequate information about program successes – because no proper monitoring and evaluation was done – is a missed opportunity to build on and possibly evolve it into a mainstream development program.	• The low level of staff skills and experience with M&E will require more than one workshop before it is fully understood and integrated into management practices. TFO staff will require practice, support and guidance over time. • CS18 senior managers and technical support staff are uneasy about the current disproportionate distribution of the Health Sector Coordinator's time in favor of the MCH-RH project. • Communities and local leaders may not have clear understanding of why the school feeding program is ending, and this could have negative impact on level of trust that has been built with TFO over the years, affecting other projects in the same communities.	• Ensure that there is one staff member (logically, the DFOD/Program) who is responsible for maintaining the M&E system, including planning follow up training for staff if needed. • Use the M&E system! Information flowing from it should be helpful in program planning meetings and development of proposals and public information. If it is not, adjust the system and find what works. • Technical assistance must be scheduled as soon as possible in order to build the CS18 staff's sense of comfort with their current management situation. The FOD and Health Sector Coordinator should work with the appropriate offices to arrange it, then advise project staff of measures being taken. • Develop project close-out plans that will ensure community understanding of why the school feeding project ended. Conduct community-level ceremonies to thank and honor all involved in the project.